State High-Risk Pools For Health Insurance

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REPORT TO THE LEGISLATURE

FROM THE HEALTH INSURANCE COMMISSIONER

STATE HIGH-RISK POOLS FOR HEALTH INSURANCE

Executive Summary

The use by states of high-risk pools for medically "uninsurable" individuals has increased steadily over the past 30 years, and 31 states now operate high-risk pools. High-risk pools are state-sponsored programs that provide health insurance coverage to individuals who have had difficulty obtaining insurance due to their health status, as well as to certain other eligible individuals.

States offer commercial insurance plans to high-risk pool enrollees. Enrollees pay premiums for coverage. State funds are used to supplement premium payments, thereby reducing the cost to participants.

High-risk pools provide insurance to individuals at a reduced rate compared to what they would find on the open market. However, because individuals who enroll in the pools usually have higher-then-average health care costs, premiums are still higher than those paid by most people outside the high-risk pool. A limited number of states provide sliding scale income-based subsidies to further reduce premiums for low-income individuals.

Almost all states accept into high-risk pools individuals who have been denied coverage due to medical reasons, and members of this group are the most frequent users of high-risk pools, constituting 72 percent of enrollees nationally in 1999.

In general, high-risk pools cover very few people and coverage is very expensive. More than 170,000 people are enrolled in high-risk pools nationally, but this enrollment remains a small fraction of the insurance market. High-risk pool premiums averaged $3,083 per year in 1999 and have grown at a rate higher than general health insurance inflation rates since then. Because premiums are high in high-risk pools, those who utilize the pools tend to be relatively high-income people.

Most high-risk pools offer more limited coverage than would be available through a group plan, cost-sharing is relatively high and enrollment is restricted. Traditional indemnity plans are the most common type of plan offered in high-risk pools. Deductibles and coinsurance generally mirror that which is available in the individual insurance market. Most high-risk pools also have lifetime benefit limits, and most states apply some condition-specific exclusions to coverage.

High-risk pools generally require significant subsidization. Loss ratios (the ratio of claims paid to premiums collected) in 1999 were greater than 100 percent for all high-risk pools, indicating claims liabilities that exceeded premiums paid. The range of these ratios was from 114 percent in Oklahoma to 484 percent in Washington.

Pools are most commonly funded through an assessment on health insurer premiums. States have also used provider assessments, general fund revenue and dedicated taxes such as cigarette taxes to fund high-risk pools.

As of the end of 2004, approximately 14,400 individuals in Rhode Island purchased coverage in the individual, or "direct pay" market. These individuals received coverage through Blue Cross and Blue Shield of Rhode Island (BCBSRI), the only carrier participating in this market. There are two types of individuals in the BCBSRI self-pay pool – those who pass a medical underwriting test ("preferred" subscribers), and those who do not ("basic" subscribers).

Until recently, the direct pay market in Rhode Island has offered a relatively effective alternative to a high-risk pool. Prior to 2004, rates for both pools were at or below group insurance rates, and BCBSRI earned appropriate, modest margins. However, in 2004 BCBSRI's medical loss ratio dropped to 99.1 percent, resulting in sizable health plan losses. BCBSRI requested rate increases to cover these losses in 2004, but was denied by the state insurance department.

The BCBSRI basic pool functions much like a high-risk pool would in another state, but with two key differences: 1. it is not reserved for the "uninsurable," and therefore allows for some spreading of risk between high- and low-risk subscribers; and, 2. there is no state revenue provided to subsidize rates**. Subsidization of the basic pool comes**

exclusively from BCBSRI self-pay preferred subscribers. Another source of subsidization will be necessary to avoid unsustainable rate increases for preferred subscribers in the future.

Access to the market is not the problem for high-risk Rhode Islanders. The problem is maintaining the subsidy necessary to make their insurance affordable. Without this subsidy, high-risk individuals end up in a market of their own, with no low-risk people to whom their costs can be spread. As high-risk prices escalate, those who remain in the market are those who need the coverage the most, placing further pressure on costs and creating an insurance "spiral."

Our policy goal is to maintain insurance pooling – to allow the costs of care for sick individuals who are not or cannot be part of a large purchasing group to be subsidized fairly and efficiently by as broad a group of healthy people as possible. If this goal is not achieved, the individual market falls apart as healthy people drop out. **Policy action is needed to achieve this goal, and thus maintain and enhance affordability in the individual insurance market. However, it is not clear that a high-risk pool offers any real advantage for Rhode Island.** Among the policy options available are:

1. **Continue the status quo, subsidizing the high-risk self-pay group through the preferred pool.**

2. **Retain the existing direct pay structure, but implement an explicit subsidy of the <u>entire</u> basic pool, through a broader financing base, ideally reaching the self insured market.**
3. **Subsidize <u>one specific</u> product offering for the basic pool. This specific offering would be designed to create appropriate incentives for members, providers and insurers to control the underlying cost of care.**
4. **Implement a requirement that all insurers participating in the group insurance market also offer coverage, on equal footing with BCBSRI, in the individual market or pay into the pool to subsidize it.**
5. **Offer individual, income-based subsidies for high-risk coverage.**

Some combination of one or more of these options offers a more prudent course than the creation of a state-run high-risk pool. The Health Insurance Commissioner looks forward to exploring these options with the General Assembly and working to develop more efficient and effective mechanism for financing health insurance for high-risk individuals in Rhode Island.

REPORT ON STATE HIGH-RISK POOLS FOR HEALTH INSURANCE

In a Joint Resolution passed in the spring of 2004, the Rhode Island General Assembly directed the Health Insurance Commissioner to undertake an evaluation of a high-risk pool for individuals with significant health expenditures. High-risk pools are used by some states to provide access to insurance for a portion of the population that is particularly vulnerable to losing or being unable to obtain health insurance, those who have health problems and do not have access to group insurance. The use of high-risk pools has increased steadily among states over the past 30 years, and 31 states now operate high-risk pools. This report reviews states' experience with high-risk pools, and highlights some of the practical and policy issues raised by this approach.

What is a high-risk pool?

High-risk pools are state-sponsored programs that provide health insurance coverage to individuals who have had difficulty obtaining insurance due to their health status, as well as to certain other eligible individuals. States offer commercial insurance plans to high-risk pool enrollees. The type of plans offered range from traditional indemnity to managed care plans. Enrollees pay premiums for coverage. State funds are used to supplement premium payments, thereby reducing the cost to participants. States subsidize high-risk pools through a variety of mechanisms, including

general fund revenues, premium taxes, targeted taxes such as the tobacco tax, and assessments on health care providers.

High-risk pools provide insurance to individuals at a reduced rate compared to what they would find on the open market. **However, because individuals who enroll in the pools usually have higher-then-average health care costs (with some having exceptionally high costs), premiums are still higher than those paid by most people outside the high-risk pool.** A limited number of states (six) provide sliding scale income-based subsidies to further reduce premiums for low-income individuals.

State use of high-risk pools

The first state high-risk pools were established in 1976 and the number of states with pools has grown steadily over the years. **Thirty-one states now operate high-risk pools with a total enrollment of more than 170,000 individuals (NAIC, 2005).**

Generally there are three types of individuals who might be eligible to enroll in high-risk pools:

1. **The medically uninsurable.** In most states, insurers may either deny coverage to individuals who are not members of an employer group plan and who have a past or present medical condition (often called a pre-existing condition), or they may charge them higher prices for health insurance.

2. **Those eligible under the Health Insurance Portability and Accountability Act (HIPAA).** HIPAA, passed by Congress in 1996, required every state to assure that certain "eligible individuals" who had lost their access to group health insurance because they left a job could still obtain individual coverage.

3. **Medicare beneficiaries seeking a supplemental insurance option.** Some Medicare beneficiaries have trouble, due to their health status, obtaining supplemental insurance to fill the gaps in their Medicare coverage. Without supplemental insurance, beneficiaries must pay directly much of their medical costs, including costs of outpatient prescription drugs.

Not all states offer coverage to all three groups. Almost all states accept into high-risk pools individuals who have been denied coverage due to medical reasons, and members of this group are the most frequent users of high-risk pools, constituting 72 percent of enrollees nationally in 1999 (Achman and Chollet, 2001).

Some states require individuals to provide proof of two denials to be eligible for high-risk pool enrollment. Some states also accept individuals who can obtain coverage, but can do so only at premium levels that exceed by an established margin those offered in the high-risk pool. As of 2001, 11 states enrolled Medicare beneficiaries who could not obtain supplemental coverage due to medical reasons. Most states also use their high-risk

pools to provide coverage to HIPAA-eligible individuals who have lost group coverage after leaving employment.

Enrollment in high-risk pools remains a small fraction of the insurance market. About seven percent of the population under age 65 obtains coverage through the individual market (Fronstin, 2000; Turnbull and Kane, 2005)). Of that population, only about 1.2 percent of each state's individual insurance market (on average, across states with high-risk pools) was enrolled through high-risk pools in 1999 (Achman and Chollet). Enrollment varies greatly across the 31 states with high-risk pools. Only two states (Minnesota and California) have more than 2,000 high-risk pool enrollees (Pauly and Nichols, 2002), and one state's pool (Minnesota) accounting for nearly a quarter of the enrollment nationwide (Chollet, 2002).

Premiums and subsidies

In general, high-risk pools cover very few people and coverage is very expensive (Turnbull and Kane; Chollet; Achman and Chollet). Premiums charged in high-risk pools vary greatly across states, and also across individuals enrolled in the same risk pool. All states cap the premiums charged to enrollees relative to the average rates charged in the individual insurance market. Typical caps range from 125 to 200 percent of the average standard rate for comparable individually purchased insurance. Nonetheless, high-risk pool premiums are high, averaging $3,083 in 1999 (Achman and

Chollet) and growing at a rate higher than general health insurance inflation rates since then (Turnbull and Kane).

Generally high-risk pools allow for some differential rating based on risk factors other than health, e.g., gender, age and geographic location. One study found that there is as much as a threefold difference in premiums charged by high risk pools for the same product based on age alone (Turnbull and Kane).

Because premiums remain high in high-risk pools, those who utilize the pools tend to be relatively high-income people (those who can afford premiums well above market rates) (Turnbull and Kane). Six states operate income-based subsidy programs for low-income high-risk pool enrollees. The programs generally include both a premium subsidy and a reduction in the annual deductible. However, due to the high premiums charged in high-risk pool, subsidies generally are not large enough to make coverage affordable for those who face the highest premiums due to their risk profile.

A recent study of coverage in the individual market found that premiums in high-risk pools in four states amounted to between 8 and 89 percent of income for people whose income was 200 percent of the federal poverty level ($17,960 for an individual, $36,800 for a family of four) (Turnbull and Kane). At the higher end of that range, state subsidies of 20 to 25 percent of premiums (the most common level offered) would not make coverage affordable to many low-income people. Another study found that individuals below 200 percent of poverty are highly unlikely to enroll in individual insurance at

market rates (let alone high-risk pool rates) unless they or a family member has a chronic condition (Pauly and Nichols).

Coverage, benefit design and limitations

States have had to strike a balance, in designing and operating high-risk pools, between a desire to provide comprehensive coverage at an affordable price and a desire to control the overall cost (and thus the subsidy cost) of the pool. In addition, states have to avoid adverse selection, where only the least healthy people enroll in the high-risk pool, driving premium costs continually higher. To do this, states try to have the products offered to potential pool enrollees mirror those offered in the state's individual insurance market to the greatest extent possible. However, insurance purchased in the individual market is typically less comprehensive than that purchased in the group market. **The result is that most high-risk pools offer more limited coverage than would be available through a group plan, cost-sharing is relatively high and enrollment is restricted.** Some states have even capped enrollment in their pools. As one author laments:

> "*high-risk pools typically mirror the individual health insurance market's problems of access, affordability and benefit adequacy, and they offer more costly and less complete coverage than many policymakers might imagine* (Chollet, 2002)."

Traditional indemnity plans are the most common type of plan offered in high-risk pools. Enrollees in pools may favor this type of plan because it allows them to use their own providers, a concern for some with existing medical problems. About half of the state high-risk pools also offer a PPO option, and at least six states offer HMO coverage (Achman and Chollet).

Deductibles in high-risk pools can be anywhere from zero (usually for PPO or HMO plans) to $10,000, depending on the type of plan. Coinsurance is usually set at about 20 percent of covered expenses beyond the deductible amount. Most, but not all, states cap out-of-pocket expenses. The limit depends on the type of plan chosen, but can be as high as $20,000 (Achman and Chollet).

Most high-risk pools also have lifetime benefit limits. The typical lifetime limit is $1 million, but there is a broad range across states. Most states also have a preexisting condition exclusion, whereby they do not cover expenses for a condition that was diagnosed during a “look-back” period, typically six months. The exclusion period is usually six months, though at least one state sets it at a year (Achman and Chollet; Communicating for Agriculture). The waiting periods, while necessary to guard states against adverse selection, unfortunately also undermine the purpose of high-risk coverage and may discourage enrollment by individuals who can not afford to pay premiums for six months or more and also continue to pay out-of-pocket for services associated with their pre-existing conditions (Chollet).

Most states also apply condition-specific exclusions to high-risk pool coverage. Nearly all pools limit or exclude mental health benefits and many limit or exclude maternity benefits. Some also limit prescription drug coverage (Chollet).

Lastly, in order to maintain low enrollment in high-risk pools and control costs, most states have limited outreach and marketing efforts.

Costs and financing mechanisms

High risk pools typically require significant subsidization. In 2003, average premiums covered only 54 percent of total costs. Total claims collected for the approximately 181,000 individuals enrolled in high-risk pools in 2003 were about $1.3 billion, while premiums paid by these individuals were about $800 million, necessitating state subsidies of almost $600 million after accounting for administrative expenses (Communicating for Agriculture). Loss ratios (the ratio of claims paid to premiums collected) were greater than 100 percent for all high-risk pools, indicating claims liabilities that exceeded premiums paid. The range of these ratios in 1999 was from 114 percent in Oklahoma to 484 percent in Washington (Achman and Chollet).

High cost cases account for most high-risk pool costs. One study found that, from 1988 to 1991, the top 5 percent highest-cost enrollees accounted for between 64 and 90 percent of high-risk pool medical expenses (Stearns et al, 1997).

High-risk pools are most commonly funded through an assessment on health insurer premiums. Insurers are assessed according to their proportional share of the insurance market. Some states allow insurers to offset the cost of the assessment against other state tax liabilities. The federal Employee Retirement Income Security Act (ERISA) exempts self-insured plans from such taxes, meaning that states are taxing only a portion of the market to pay for high-risk pools, and placing insured plans at a disadvantage. Some states have avoided this problem by assessing stop-loss insurers and reinsurers, and so far courts have held that this is legal. Two states have achieved the same goal by levying a tax on hospitals inpatient admissions and outpatient procedures (Butler, 2000).

A handful of states use general revenues to fund their high-risk pools. Others use designated funds, such as a tobacco products surtax (California), funds from unclaimed property (Colorado) and tobacco settlement funds (Kentucky).

Is a high-risk pool needed in Rhode Island?

The purpose of health insurance, like all other insurances, is to spread risk. Individuals purchase coverage as a safeguard against the possibility of incurring unusually high costs at some point in the future. Everyone pays so that they can have peace of mind, but all who pay do not draw on their coverage at the same rate – some have high costs, some have low costs. Unfortunately, much of the business of modern-day insurance is about risk avoidance, rather than risk spreading. It has become increasingly easy to identify those people who are most likely to have high health care costs. Insurers often attempt to

segregate the market so that they do not end up covering those individuals. At some point, this leads to market failure for those high-risk individuals. As they are priced out of the regular market and end up in the high-risk market, there are fewer low-cost people to spread costs to. As high-risk prices escalate, those who remain in the market are those who need the coverage the most, placing further pressure on costs and creating an insurance "spiral."

At the same time, more large groups are moving their business to the self-insured market, whereby the groups create their own insurance pool, often with stop-loss insurance or reinsurance for very large claims. The effect of this trend is to leave fewer people in the insured market, further reducing the base across which health care costs can be spread.

Rhode Island has public policies to limit the penalizing of sick individuals in the health insurance market. It is a "guaranteed issue state," meaning health plans cannot deny applications for insurance. This, combined with regulation of rates in the small group and individual markets, helps ensure access to the market for all individuals, regardless of their health status. However, this policy also results in a limited number of insurance companies doing business in the Rhode Island market, as the opportunity for profits is limited.

As is the case in most states, most Rhode Islanders with health insurance are covered by group insurance plans. About 725,000 people receive coverage through such plans. Another 175,000 are covered by Medicaid, and 155,000 by Medicare. As of the end of

2004, approximately 14,400 individuals in Rhode Island purchased coverage in the individual, or "direct pay" market. About 106,000 Rhode Islanders had no coverage at all in 2004.

Coverage in the direct pay market is provided exclusively by Blue Cross and Blue Shield of Rhode Island (BCBSRI). BCBSRI offers three products to individuals and their families: a standard indemnity plan; an indemnity plan with reduced benefits; and a preferred provider (PPO) product. Premiums paid by individuals who enroll in these plans vary in several ways. First, those who pass a medical underwriting test, which assesses in part whether they have pre-existing conditions, are given "preferred" rates. Those who do not pass this test pay "basic" rates. Slightly more than half of the enrollees in 2004 paid the basic rates. Second, within the preferred rating pool rates vary according to age and sex (women and older people generally pay higher premiums), while in the basic pool they vary only by very general age categories (over 65 and under 65). Lastly, the premiums vary according to plan design and benefit coverage, with premiums for the standard indemnity plan being the highest. Premiums for a single male in his 20s range from $105.31 to $167.58 monthly in the preferred pool. Premiums for a woman in her 50s range from $285.92 to $429.81 monthly in the preferred pool. Premiums for both individuals would range from $310.28 to $471.38 in the basic pool, depending on the plan chosen.

Until recently, the direct pay market in Rhode Island has offered a relatively effective alternative to a high-risk pool. Prior to 2004, rates for both the basic and the

preferred pools were at or below group insurance rates, and BCBSRI earned appropriate, modest margins. However, in 2004 BCBSRI's medical loss ratio dropped to 99.1 percent, resulting in sizable health plan losses. BCBSRI requested a rate increase in 2004, but that request was denied by state regulators due to concerns about the affordability of coverage in the self-pay market.

The BCBSRI basic pool functions much like a high-risk pool would in another state, with two key differences. First, the pool is not reserved for the "uninsurable" and therefore allows for some spreading of risk between high- and low-risk subscribers. The underwriting rules place about one-half of the direct pay population in the basic pool and one-half in the preferred pool. This allows for a more affordable rate for the basic pool population, relative to what they would likely pay in a high-risk pool. Second, there is no state revenue provided to subsidize rates for subscribers in the basic pool. However, there is some subsidization of the BCBS basic pool by the preferred pool. While the base rate is higher in the basic pool, recent rates of increase in premiums have been applied evenly across all self-pay subscribers, even though claims have risen faster in the basic pool. Subsidization of the basic pool comes exclusively from BCBS self-pay preferred subscribers.

High-risk pools are typically set up for two reasons: (1) To ensure access to insurance for high risk individuals; and (2) To subsidize premiums for these high risk individuals in order to enhance the affordability of insurance. Access to the market is not the problem for high-risk Rhode Islanders. BCBSRI already has a pool with products that are more

comprehensive than those offered in many high-risk pools and at premiums that are probably lower than most high-risk pools. Enrollment in the basic pool has remained stable for several years. In fact, any effort to create a more traditional high-risk pool would likely increase rates and therefore reduce access to insurance for high-risk individuals.

The issue in Rhode Island is finding a way to maintain the subsidy necessary to make insurance affordable for high-risk individuals. Without this subsidy, high-risk individuals end up in a market of their own, with no low-risk people to whom their costs can be spread. As high-risk prices escalate, those who remain in the market are those who need the coverage the most, placing further pressure on costs and creating an insurance "spiral."

Currently, healthy self-pay subscribers are subsidizing the less healthy. Cost pressures on Rhode Island's insured population are intense. In 2003, Rhode Island ranked 8th highest in the country for average commercial premiums for single coverage. Rates of increase have averaged 8-12 percent annually for the past three years. These rates are not sustainable and, therefore, any additional pressure created by the cross-subsidization necessary to suppress rates in the self-pay basic pool must be examined carefully. As the cost of this subsidization increases, we run the risk of driving the healthy subscribers from the market, and reduce the likelihood that uninsured Rhode Islanders will be able to purchase individual coverage in the future. Another source of subsidization will be necessary to avoid unsustainable rate increases for preferred self-pay subscribers in the

future. **In this sense, policy action is needed to maintain and enhance affordability in the individual insurance market.**

Several policy options are worth considering to address these issues. These include:

1. **Continue the status quo, subsidizing the high-risk self-pay group through the preferred pool.** This is an option for absorbing claims cost increases associated with the basic pool, but will probably result in unsustainable rate increases for preferred subscribers in the future

2. **Retain the existing direct pay structure, but implement an explicit subsidy of the <u>entire</u> basic pool, through a broader financing base, ideally reaching the self insured market.** BCBSRI is placed at a disadvantage in the market by the current financing of the basic pool and that is not an arrangement we can expect the company to sustain. The basic pool provides insurance for some of the highest-risk Rhode Islanders. For the burden of their costs to be spread only across other self-pay subscribers is untenable. Subsidization in a manner that makes clear the costs and spreads them more evenly across the market would make more sense and be more sustainable. While a number of financing mechanisms might be viable, it would be best to spread the high-risk costs as broadly as possible across. As long as subsidies for the high-risk group are derived from the insured market, the costs will not be spread across those who are

covered through self-insured plans. It is estimated that 15-20 percent of the Rhode Island insured population is in self-insured plans.

3. **Subsidize one specific, more cost-effective product for the basic pool.** BCBSRI estimates medical inflation for the direct pay products at 17 percent for the past two years. This compares to 8-12 percent for the commercial group market. One reason for this discrepancy is the product design – current direct pay products offer little incentive for members, providers and insurers to make cost effective decisions about health care. This specific offering could be designed to create appropriate incentives to control the underlying cost of care. Additionally, by subsidizing a single product option which aligns incentives toward the goal of cost effective decision-making, medical cost increases will be more in line with (or below) experience in the rest of the insurance market, and less subsidy will be required to maintain an affordable product.

4. **Implement a requirement that all insurers participating in the group insurance market also offer coverage, on equal footing with BCBSRI, in the individual market or pay into the pool to subsidize it.** Currently BCBSRI is the only carrier that participates in the individual health insurance market. The state could require other carriers to participate as a condition of doing business in the group insurance market. If this option is pursued, we will need to guard against potential "cherry-picking" of the market by carriers, whereby a carrier uses targeted marketing and other means to avoid higher-risk customers and

attract lower-risk customers. Such practices could undermine seriously attempts to maintain a broad risk pool in the self-pay market by fragmenting the risk pool into higher-and lower-risk groups. Alternatively, carriers could pay an assessment to help fund high-risk coverage through BCBSRI.

5. **Offer individual, income-based subsidies for high-risk coverage.** While coverage in the BCBSRI basic pool is more affordable than that available in the high-risk pools in many states, it can still be very expensive for low-income Rhode Islanders. The state could consider subsidizing individuals to purchase coverage, in addition to subsidizing the entire pool by holding down rates (the advantage of which accrues only to those who can afford to purchase the coverage).

While Rhode Island's individual insurance market is not perfect, it is functioning better than that of many states. Nonetheless, the market could be strengthened through some combination of one or more of the actions outlined above. At this time, this would be a more prudent course of action than would be the creation of a high-risk pool. With only two commercial carriers in the state, the financing of a more explicit, coherent and sustainable system of subsidies for high-risk individuals is simple. We don't need an elaborate financing formula or an elaborate (and potentially costly) high-risk pool apparatus. By building on what we have, rather than carving out a new high-risk pool, we can develop a more efficient and effective mechanism for financing health insurance for high-risk individuals. This mechanism should be designed to coordinate with more

general efforts to increase the affordability of health insurance in the individual and small group markets.

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